U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 19 May 2006

CASE NO.: 2004-BLA-5502

In the Matter of:

WALTER L. KINCAID,
Claimant

v.

CARBON FUEL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Otis Ray Mann, Jr., Esq.
For the Claimant

Ashley Harman, Esq.
For the Employer

BEFORE: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended ("Act"), filed on August 24, 2001, respectively. The act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his prior claim for benefits on September 23, 1981. (DX 1). On September 12, 1989, Administrative Law Judge Marcellino issued a Decision and Order Denying Benefits. Administrative Law Judge Marcellino found that Mr. Kincaid had coal workers' pneumoconiosis. He further found, however, that Mr. Kincaid was not totally disabled. Thus, benefits were denied. The Claimant appealed this decision. The appeal was later dismissed due to abandonment of the claim. (DX 1).

The claimant filed his current claim for benefits on August 24, 2001. (DX 2). On September 12, 2003, the claim was approved by the district director because the evidence established the elements of entitlement. (DX 21). On September 19, 2003, Employer requested a formal hearing before the Office of Administrative Law Judges. (DX 22). An October 28, 2004 hearing before the undersigned was continued at the request of both parties. Thereafter, a February 16, 2005 hearing before the undersigned was continued due to the miner being hospitalized.

On October 18, 2005, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The miner, Walter L. Kincaid, passed away prior to the hearing, on September 30, 2005. Mr. Kincaid's family pursued the claim on his behalf. The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-5, Director's exhibits ("DX") 1-30, and Employer's exhibits ("EX") 1, 2, 4, 5, 6, 10, and 11[2] were admitted into the record. Employer's exhibits 8 and 9 were conditionally admitted at the hearing. After consideration, I hereby formally admit Employer's exhibits 8 and 9 into the record.

Post-hearing evidence consists of exhibits closing arguments submitted by both parties.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Employer's exhibits 3 and 7 were not admitted due to exceeding the evidentiary limitations at Section 725.414. Additionally, the CT scan reading by Dr. Scott included in Employer's exhibit 1 was excluded as cumulative evidence. Dr. Scott's X-ray interpretation included in Employer's exhibit 5 was not admitted due to exceeding the Section 725.414 evidentiary limitations.

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner was totally disabled?

IV. Whether the miner's disability was due to pneumoconiosis?

V. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 18 years, as stipulated to by the parties. (Hearing Transcript (TR) 6).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on August 24, 2001. (DX 3). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Carbon Fuel Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G, Part 725 of the Regulations.

D. Dependents

The claimant has no dependents for purposes of augmentation of benefits under the Act.

E. Personal, Employment and Smoking History[4]

The decedent miner was born on September 6, 1923. (DX 2). He passed away on September 30, 2005. He married Una Kincaid on May 24, 1946. His wife is deceased. (DX 2). Mr. Kincaid left the coal mines in 1982. (DX 2). The claimant's last position in the coal mines was that of a section foreman. He held this position for approximately twenty years. This

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[4] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

position required him to lift 50 to 75 pounds numerous times a day. As such, I find that his position in the coal mines required heavy manual labor.

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. As the miner passed away prior to the hearing, there is no testimony regarding his smoking history. Thus, to determine how long he smoked, I must consider the smoking history he communicated to the physicians. Mr. Kincaid testified at a June 27, 1989 claim that he smoked one pack of cigarettes per day for twenty-five years. Dr. Castle concluded that Mr. Kincaid smoked between thirty and fifty years. Dr. Crisalli found a 20-pack year smoking history. Dr. Gaziano noted that Mr. Kincaid smoked a ½ pack of cigarettes per day for approximately 40 years. Based on these reports, I find that Mr. Kincaid smoked one pack of cigarettes per day for twenty-five years, quitting in the early 1980's. A finding of greater than twenty-five years would have no effect on this decision.

II. Medical Evidence

A. Chest X-rays[5]

There were twelve readings of three X-rays, taken on October 4, 2001, April 8, 2002, and August 26, 2004. (DX 9, 10, 11; CX 1, 2, 3; EX 2, 5). Five are positive, by three physicians, Drs. Ahmed, Cappiello and Gaziano, all of whom are either B-readers, Board-certified in radiology, or both.[6] Six are negative, by three physicians, Drs. Scott, Wheeler and Wiot, all of whom are B-readers and Board-certified in radiology. Dr. Binns provided a quality-only reading of the October 4, 2001 X-ray.

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 5	8/26/2004 11/23/2004	Dr. Wheeler	B, BCR	2		No pneumoconiosis. Marks compatible with emphysema.
CX 2	8/26/2004 9/27/2004	Dr. Ahmed	B, BCR	1	2/2	q/p all zones.
CX 1	8/26/2004 8/26/2004	Dr. Gaziano	B, BCI(P)	2	1/1	q/s all zones.
DX 11	4/8/2002 7/3/2002	Dr. Wheeler	B, BCR	2		Emphysema.
DX	4/8/2002	Dr. Scott	B, BCR	2		Emphysema.

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e) (effective Jan. 19, 2001).

[6] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n.16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
11	7/3/2002					
EX 2	10/4/2001 10/23/2003	Dr. Wiot	B, BCR	2	0/1	p/q upper zones.
DX 9 CX 3	10/4/2001 6/18/2002	Dr. Cappiello	B, BCR	2	2/1	p/q all zones.
DX 11	10/4/2001 4/24/2002	Dr. Wheeler	B, BCR	2		Emphysema.
DX 11	10/4/2001 4/24/2002	Dr. Scott	B, BCR	3		No abnormalities consistent with CWP.
DX 9	10/4/2001 6/14/2001	Dr. Ahmed	B, BCR	2	2/2	q/p. all zones.
DX 10	10/4/2001 11/2/2001	Dr. Binns	B, BCR	2		Scapula overlay. Quality only reading.
DX 10	10/4/2001 10/4/2001	Dr. Gaziano	B, BCI(P)	1	1/1	q/s all zones.

Chest X-rays Submitted in the Miner's First Claim for Benefits: (DX 1)

Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
4/20/1989 4/29/1989	Dr. Gaziano	B, BCI	1	1/0	q/s all right zones. Mid and lower left zone.
10/3/1985 10/7/1985	Dr. Gogineni	B, BCR	2	1/1	q/t. all zones.
3/11/1982 3/14/1982	Dr. Gaziano	B, BCI	1	1/1	Q All zones.
4/29/1981 4/29/1981	Dr. Zaldivar	B, BCI(P)	acceptable	1/0	

* A-A-reader; B-B-reader; BCR – Board Certified Radiologist; BCP – Board-Certified Pulmonologist; BCI – Board-Certified Internal Medicine; BCI(P) – Board-Certified Internal Medicine with Pulmonary Medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified, as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the

presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

CT Scans

The record contains the results of a July 26, 2001 CT scans read by Board Certified Radiologists. A CAT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A CAT scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves recoding of 'slices' of the body with an X-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, bringing them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal Co. v. Director, OWCP [Stein]*, __ F.3d __, 22 B.LR. 2-409, 2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the miner does not have pneumoconiosis. The DOL has rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

Dr. Leef is a B-reader and Board-certified radiologist and medical examiner. Dr. Leef reviewed the July 26, 2001 CT scan. Dr. Leef found atherosclerotic disease in the aorta. He found no evidence of pulmonary emboli. He also noted some chronic changes within the lungs. (EX 6).

Dr. Ahmed is a B-reader and Board-certified radiologist. Dr. Ahmed interpreted the July 26, 2001 CT scan as showing multiple small pneumoconiotic opacities in both lung fields. He noted that the profusion is 2/2. Dr. Ahmed noted changes of chronic obstructive pulmonary disease with emphysematous bullae. He found coalescence of small pneumoconiotic opacities and lymph nodes measuring up to 1 cm. in the superior mediastinum. (CX 4).

Dr. Aycoth, a B-reader and Board-certified radiologist, found the July 26, 2001 CT scan to show coal workers' pneumoconiosis category 1/1. Dr. Aycoth noted scattered rounded density opacities measuring up to 1.5 mm in diameter throughout both lungs. (CX 5).

Dr. Wheeler, a B-reader and Board-certified radiologist, interpreted the July 26, 2001 CT scan. Dr. Wheeler found no evidence of silicosis or coal workers' pneumoconiosis. Dr. Wheeler noted few small linear scars in lateral periphery lungs associated with focal bilateral pleural fibrosis and possible few tiny calcified benign asbestos related pleural plaques. (EX 1).

Dr. Wiot, a B-reader and Board-certified radiologist, reviewed the July 26, 2001 CT scan. (DX 11). Dr. Wiot found no evidence of coal workers' pneumoconiosis. He stated that the lung fields showed mild emphysema. (DX 11).

Subsequent to the hearing, the board changed its earlier ruling concerning the admission of CT scans. In *Webber v. Peabody Coal Co.*, 23 B.L.R. 1 - __, BRB No. 05-0335 BLA (Jan. 27, 2006)(*En banc*) and *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1 - __, BRB No. 04-0812 BLA (Jan. 27, 2006)(Arising in 7th Cir.), the Board held that Section 718.107 requires that "only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence." The interpretation by Dr. Leef was admitted at the hearing as a treatment record. As such, I will consider that interpretation as a treatment record not subject to *Webber*. I designate Dr. Ahmed's interpretation as Claimant's one interpretation submitted as affirmative evidence. I designate Dr. Wheeler's interpretation as Employer's one interpretation submitted as affirmative evidence. I will also consider the interpretations of Drs. Aycoth and Wiot as rebuttal evidence.

B. Pulmonary Function Studies[7]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV1) and maximum voluntary ventilation (MVV).

Physician Date Exh. #	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform
Dr. Gaziano 8/26/2004 CX 1	80 65"	1.40	46	2.33	Yes		No Yes
Dr. Gaziano 8/26/2004 CX 1 Post-Bron	80 65"	1.32		2.44	Yes		Yes Yes
Dr. Crisalli 4/8/2002 DX 11	78 66.5"	1.30	42	2.50	Yes	Fair	Yes Yes
Dr. Crisalli 4/8/2002 DX 11 Post-Bron	78 66.5"	1.56		2.94	Yes	Fair	Yes Yes
Dr. Gaziano 10/4/2001[8] DX 10	78 66"	1.13	43	2.20	Yes	Good Good	Yes Yes

[7] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

[8] On November 6, 2001, a physician reviewed this test and found that the vents are acceptable. The signature of the reviewing physician is illegible. (DX 10).

Pulmonary Function Studies Submitted in the Miner's First Claim for Benefits: (DX 1)

Physician Date	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform
Dr. Gaziano 4/20/1989	65 67"	1.92	83	3.30	Yes		No Yes
Dr. Crisalli 10/3/1985	62 69"	1.87	93	3.26	Yes	Good Good	No Yes
Dr. Gaziano 3/11/1982	58 68"	2.15	93	3.28	Yes	Good Good	No Yes
Dr. Zaldivar 4/29/1981	57 67.5"	2.268	108	3.67	Yes	Valid effort	No Yes

* A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanies by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of 66 inches, § 718.204(b)(2)(i) requires an FEV1 equal to or less than 1.57 for a male 71[9] years of age.[10] If such an FEV1 is shown, there must be in addition, an FVC equal to or less than 2.04 or an MVV equal to or less than 63; or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test. Dr. Gaziano's October 4, 2001 test, Dr. Crisalli's tests, and Dr. Gaziano's August 26, 2004 post-bronchodilator test all qualify under the FEV1/FVC ratio.

[9] Appendix B does not list qualifying values for miners over the age of 71.

[10] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th Cir. 1995). I find the miner is 66" here, his average reported height for the pulmonary function studies submitted in the current claim.

C. Arterial Blood Gas Studies[11]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Exh. #	Physician	PCO2	PO2	Qualify
8/26/2004 CX 1	Dr. Gaziano	42	63	No
4/8/2002 DX 11	Dr. Crisalli	46	60	Yes
10/4/2001 DX 10	Dr. Gaziano	41	69	No

Arterial Blood Gas Studies Submitted in the Miner's First Claim for Benefits: (DX 1)

Date	Physician	PCO2	PO2	Qualify
4/20/1989	Dr. Gaziano	38 42*	78 88*	No No
10/3/1985	Dr. Crisalli	42	66	No
3/11/1982	Dr. Gaziano	38 36*	73 77*	No No
4/29/1981	Dr. Zaldivar	34 32*	71 84*	No No

* Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports[12]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary

[11] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. § 204(b)(2) permits the use of such studies to establish "total disability." It provides:

In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii) or (iv) of this section shall establish a miner's total disability:…

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

[12] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Castle, a B-reader and Board-certified in internal medicine and pulmonary disease, reviewed Mr. Kincaid's medical records. (EX 4). In his April 7, 2004 report, Dr. Castle noted a 32 year coal mine employment. After reviewing the physical examinations, chest X-rays interpretations, CT scan interpretations, arterial blood gases and pulmonary function studies, Dr. Castle concluded that Mr. Kincaid did not have coal workers' pneumoconiosis. (EX 4).

Dr. Castle noted that the smoking history presented by Mr. Kincaid varied from 30 years to 50 years. Dr. Castle stated that either of these figures is sufficient to cause chronic obstructive pulmonary disease. He also noted that the X-rays and CT scan demonstrate evidence of bullous emphysema. Dr. Castle explained that bullous emphysema is not seen in coal workers' pneumoconiosis. He stated that it is a tobacco smoke induced lung diseases. (EX 4).

Dr. Castle opined that Mr. Kincaid was disabled from a pulmonary standpoint. He found the disability was due to tobacco smoke induced chronic obstructive airway disease. (EX 4).

Dr. Castle prepared a supplemental report, dated December 28, 2004. (EX 8). Dr. Castle reviewed Dr. Gaziano's report. Dr. Castle concluded that Dr. Gaziano's report did not change his opinion that Mr. Kincaid did not have coal workers' pneumoconiosis. Dr. Castle again found that Mr. Kincaid was disabled as a result of tobacco smoke induced chronic obstruction with pulmonary emphysema. (EX 8).

Dr. Castle was deposed on January 26, 2005. (EX 10). Dr. Castle testified that a 32-year history of working in the coal mines is significant risk factor for someone to develop coal workers' pneumoconiosis if he were a susceptible host. (EX 10, p. 9). Dr. Castle explained that Mr. Kincaid did not demonstrate consistent findings of interstitial pulmonary process. He explained that the miner did not have consistent findings of rales, crackles or crepitations. (EX 10, p. 11).

Dr. Castle explained that the bullous emphysema found on Mr. Kincaid's X-rays and CT scan is the type of emphysema caused by tobacco smoke or an inherited condition known ad alpha-1 antitrypsin deficiency. (EX 10, p. 13).

Dr. Castle testified that Mr. Kincaid's pulmonary function studies presented an airway obstruction. He noted that some tests revealed a very significant degree of reversibility in the airway obstruction after the use of bronchodilators. He explained "[W]hen coal workers' pneumoconiosis causes impairment, it generally does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect, and that was not the finding in this case." (EX 10, p. 15).

In terms of disability, Dr. Castle testified "[I]t would be my opinion that he is disabled as a result of his tobacco smoke-induced chronic airway obstruction. He is also disabled in my opinion because of his age." (EX 10, p. 19).

Dr. Crisalli is Board-certified in internal medicine and pulmonary diseases. He examined the miner on April 8, 2002. His report, dated July 12, 2002, diagnosed Mr. Kincaid with chronic bronchitis, emphysema, hypertension and obesity. Dr. Crisalli noted a 32-year coal mine employment and a 20 pack-year smoking history. Dr. Crisalli stated that Mr. Kincaid stopped smoking twenty years prior to the examination. (DX 11).

Dr. Crisalli noted that Mr. Kincaid had shortness of breath for twenty years, dyspnea on exertion, and cough productive of sputum for ten years. Mr. Kincaid began using home oxygen at night about six months prior to the examination. (DX 11).

Dr. Crisalli explained that an examination of the lungs showed no evidence of upper airway obstruction. He noted decreased chest wall motion and decreased breath sounds bilaterally consistent with emphysema. (DX 11).

Dr. Crisalli stated that Mr. Kincaid provided variable effort during the pulmonary function studies. He stated that because of the variability, the spirometry data was not valid. The test results show an obstruction to airflow, a severe degree of air trapping, and a mild diffusion impairment. (DX 11).

Dr. Crisalli concluded "there is not sufficient evidence to justify a diagnosis of coal workers' pneumoconiosis or any chronic dust disease of the lung caused by, significantly related to, or substantially aggravated by coal mine employment with respect to Mr. Kincaid." He explained that the history of cough productive of sputum is evidence of chronic bronchitis. He also explained that the physical examination, chest X-rays, and pulmonary function studies confirm emphysema caused by tobacco smoke exposure. (DX 11).

In determining the level of impairment, Dr. Crisalli stated "Mr. Kincaid may well be disabled from performing his previous job in the coal mines based on his pulmonary function impairment." Dr. Crisalli found the impairment was caused by tobacco smoke-related diseases of emphysema and chronic bronchitis. (DX 11).

Dr. Crisalli prepared a supplemental report, dated January 17, 2005. (EX 9). Dr. Crisalli reviewed Dr. Gaziano's report. Dr. Crisalli again found that there was insufficient evidence to justify a diagnosis of coal workers' pneumoconiosis. Dr. Crisalli stated that the objective evidence reflects "emphysema with obstruction to airflow and a severe degree of air trapping, all of which are consistent with Mr. Kincaid's heavy tobacco smoke experience." Dr. Crisalli explained that Mr. Kincaid's type of emphysema is not the type related to coal dust exposure. Dr. Crisalli concluded that Mr. Kincaid was disabled due to smoking induced emphysema. (EX 9).

Dr. Crisalli was deposed on October 10, 2005. (EX 11). Dr. Crisalli stated that Mr. Kincaid worked in the mines for approximately 32 years and performed heavy manual labor. Dr. Crisalli discussed the findings of his examination of Mr. Kincaid. He stated that an examination

of Mr. Kincaid's chest and lungs revealed decreased motion of the chest wall. He explained that this is a finding consistent with emphysema. (EX 11, p. 8).

Dr. Crisalli stated that Mr. Kincaid communicated to him that he smoked about one pack of cigarettes per day for twenty years, quitting twenty years prior to his 2002 examination with Dr. Crisalli. (EX 11, p. 10).

Dr. Crisalli also discussed the pulmonary function study performed during his examination of Mr. Kincaid. He stated that the study was difficult to interpret due to variability. He stated that Mr. Kincaid never plateaued. He found it reasonable to conclude that obstruction to air was present. But, he could not be sure of the degree of obstruction to airflow. Dr. Crisalli also noted a significant improvement after bronchodilators. He concluded that the spirometry examination suggests the presence of emphysema. He testified "[A]ir trapping of this degree and this type is consistent with and highly suggestive of the diagnosis of emphysema." (EX 11, pp. 18-19). Dr. Crisalli explained that reversibility is not a common characteristic of coal workers' pneumoconiosis. (EX 11, p. 21). Dr. Crisalli testified that, based upon the pulmonary function studies, Mr. Kincaid would not have been able to perform his last coal mine work. (EX 11, p. 25). Dr. Crisalli attributes the impairment to heavy tobacco smoke exposure.

Dr. Crisalli also stated that he would contribute the miner's chronic bronchitis to cigarette smoking. He explained that cigarette smoking causes chronic bronchitis which is often persistent even after one stops smoking. He further explained that any bronchitis related to coal dust exposure would clear up and stop once the exposure ceases. (EX 11, p. 30).

Dr. Gaziano is a B-reader and Board-certified in pulmonary medicine, internal medicine and critical care. Dr. Gaziano examined the miner on October 4, 2001. (DX 10). His report notes thirty-two years of coal mine employment. He also noted that Mr. Kincaid smoked a half a pack of cigarettes per day on and off from 1943 until 1981. The miner communicated the following symptoms to him at the examination: sputum, wheezing, dyspnea, cough and ankle edema. Dr. Gaziano remarked that Mr. Kincaid was on oxygen at the time of the examination. (DX 10).

Based on arterial blood gases, a pulmonary function study and a positive chest X-ray, Dr. Gaziano diagnosed Mr. Kincaid with coal workers' pneumoconiosis and chronic obstructive lung disease. As the etiology of the cardiopulmonary diagnoses, Dr. Gaziano listed coal mining and cigarette smoking. (DX 10).

When asked on the examination form the degree of severity of the impairment, Dr. Gaziano wrote "unable to work in coal mining." Dr. Gaziano noted that the miner's coal mining work caused a moderate impairment. (DX 10).

Dr. Gaziano examined Mr. Kincaid for a second time on August 26, 2004. (CX 1). Dr. Gaziano stated that a chest X-ray taken during the examination showed rounded and irregular opacities in all lung zones of a 1/1 profusion. He noted that a pulmonary function test showed a moderate obstructive and restrictive ventilatory impairment. He stated that moderate decrease in arterial oxygen tension was demonstrated in an arterial blood gas study. Dr. Gaziano reiterated his conclusion that Mr. Kincaid had "coal workers pneumoconiosis and chronic obstructive

pulmonary disease with a moderate degree of pulmonary function impairment." Dr. Gaziano opined that Mr. Kincaid was unable to do his former coal mine work. (CX 1).

Physician Reports Submitted in the Miner's First Claim for Benefits: (DX 1).

Dr. Gaziano examined Mr. Kincaid on March 11, 1982. He noted a 28-year coal mine employment. He stated that Mr. Kincaid smoked one pack of cigarettes per day for 15 years, quitting in 1981. Based upon his examination and the objective testing performed, Dr. Gaziano diagnosed Mr. Kincaid with coal workers' pneumoconiosis.

Dr. Gaziano submitted an additional report, dated April 29, 1989. Dr. Gaziano noted a 32 year coal mine employment and a 30 year smoking history. Dr. Gaziano noted that Mr. Kincaid got short of breath walking up hill or on an incline. Dr. Gaziano diagnosed Mr. Kincaid with coal workers' pneumoconiosis and chronic obstructive pulmonary disease. He also stated "[H]e has approximately 40% pulmonary functional impairment which would preclude him from doing most work in the underground mines."

Dr. Abrahams is a B-reader and Board-certified in internal medicine. He provided a report based on his review of the miner's medical records. Dr. Abrahams noted a 32 year coal mine employment and 45-50 years of smoking ½ pack of cigarettes per day. After reviewing the physician opinions and objective testing, Dr. Abrahams concluded that Mr. Kincaid suffered from mild simple coal workers' pneumoconiosis, chronic bronchitis due to cigarette smoke, and mild hypertension. Dr. Abrahams determined that Mr. Kincaid was not totally disabled.

Dr. Kress, a pulmonologist and B-reader, prepared a report, dated October 28, 1988. Dr. Kress reviewed opinions and test results by Drs. Gaziano and Crisalli. Dr. Kress found sufficient objective evidence to justify a diagnosis of simple coal workers' pneumoconiosis. Dr. Kress did not find any evidence of a restrictive ventilatory impairment. He found a mild obstructive ventilatory impairment. Based on all the breathing tests, Dr. Kress concluded that Mr. Kincaid did not have a pulmonary impairment attributable to coal workers' pneumoconiosis. Dr. Kress determined that the mild obstructive impairment was due to a heavy smoking history. Dr. Kress did not find the impairment totally disabling.

Dr. Crisalli examined Mr. Kincaid on October 3, 1985. He noted a 32 year coal mine employment. He stated that Mr. Kincaid had a "heavy smoking history." A pulmonary function study showed moderate obstruction to airflow with air-trapping present. Dr. Crisalli diagnosed Mr. Kincaid with coal workers' pneumoconiosis, chronic bronchitis and a history of hypertension. Dr. Crisalli concluded that Mr. Kincaid was not totally disabled.

Dr. Crisalli submitted a letter, dated September 12, 1988. The letter states:

> Based on the data noted in my report of November 13, 1985, I feel Mr. Kincaid retained the pulmonary capacity to perform heavy labor such as lifting, pulling, carrying, crawling, etc. In response to your second question, cigarette smoking is statistically more likely to have caused Mr. Kincaid's pulmonary obstruction as opposed to coal workers' pneumoconiosis.

Dr. Zaldivar examined Mr. Kincaid on April 29, 1981. Dr. Zaldivar noted the miner's symptoms as shortness of breath, difficulty walking uphill, and cough productive of sputum. Dr. Zaldivar found a mild obstructive airway impairment, mild resting hypoxemia, and radiographic evidence of simple pneumoconiosis. Dr. Zaldivar concluded that the mild impairment is caused by coal dust exposure and cigarette smoking.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4604 (6th Cir. July 31, 2003), *citing Greenwich Collieries [Ondecko]*, 512 U.S. 267 at 281.

Since this is the miner's second claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[13] Although the new regulations dispense

[13] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Section 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that he individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or

with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc) rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. Section 725.309(d); *White v. New White Coal Co.*, *Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of September 12, 1989, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.*, 117 S.Ct. 763 (1997). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines,* 86 F.3d at 1363, n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.)*, the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

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sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see §725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

The claimant's first application for benefits was denied because the evidence failed to show that the claimant was totally disabled by pneumoconiosis. (DX 1). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

As discussed below, I find that the Claimant has proven by a preponderance of the newly submitted evidence that Mr. Kincaid was totally disabled at the time of his death. Thus, he has proven a material change in an applicable element of entitlement. As such, the evidence of the prior claim for benefits will be evaluated with the evidence in the current claim to determine if the Claimant is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R § 718.201.[14]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14

[14] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis,

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal Pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis, if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 14 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[15] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3rd Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 91991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are

[15] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B..R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-231, n.5 (1985). A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990

Three chest X-rays were interpreted for the miner's current claim for benefits. The most recent X-ray is dated August 26, 2004. Two dually qualified physicians, Drs. Ahmed and Wheeler, interpreted the X-ray. Dr. Ahmed interpreted the X-ray as having a 2/2 profusion for coal workers' pneumoconiosis. Dr. Wheeler found marks of emphysema and no evidence of pneumoconiosis. Additionally, Dr. Gaziano, who is a B-reader and Board-certified pulmonologist, interpreted the X-ray as having a 1/1 profusion for pneumoconiosis. Given the conflicting readings, I find the August 26, 2004 X-ray in equipoise.

An April 8, 2002 X-ray was interpreted by two dually qualified physicians as showing evidence of emphysema. They found no evidence of coal workers' pneumoconiosis. There are no conflicting interpretations of this X-ray. Therefore, I find the April 8, 2002 X-ray negative for coal workers' pneumoconiosis.

The October 4, 2001 X-ray was interpreted by five dually qualified physicians and Dr. Gaziano, whom is a B-reader and Board-certified pulmonologist. Dr. Binns provided a quality-only reading. Three dually-qualified physicians interpreted the X-ray as negative for coal workers' pneumoconiosis. Two dually-qualified physicians interpreted the X-ray as positive for coal workers' pneumoconiosis. Additionally, Dr. Gaziano interpreted the X-ray as positive for coal workers' pneumoconiosis. Although there are three positive and three negative readings of this X-ray, I find the October 4, 2001 X-ray negative for coal workers' pneumoconiosis based on the three dually-qualified physicians interpreting the X-ray as negative. I give somewhat more weight to Dr. Wiot's negative reading given his role in the development of the ILO classification system and experience dealing with CWP.

Four X-ray interpretations were submitted in the miner's first claim for benefits. All four readings were positive for coal workers' pneumoconiosis. As such, I find that the X-ray evidence submitted in the miner's first claim for benefits is positive for coal workers' pneumoconiosis.

As discussed above, the record also contains a July 26, 2001 CT scan. Five dually qualified physicians interpreted the CT scan. Two of the physicians found evidence of coal workers' pneumoconiosis. Three of the physicians found no evidence of coal workers' pneumoconiosis. Based on the majority of the interpretations being negative for coal workers' pneumoconiosis, I find that the July 26, 2001 CT scan is negative for coal workers' pneumoconiosis.

In summary, I find the August 26, 2004 X-ray in equipoise. I find the April 8, 2002 and October 4, 2001 X-rays negative for coal workers' pneumoconiosis. Also, I find the four X-rays submitted in the miner's first claim for benefits positive for coal workers' pneumoconiosis. However, I find that, as pneumoconiosis is a progressive disease, the X-rays submitted in the

current claim are entitled to the most weight. Additionally, I find the July 26, 2001 CT negative for coal workers' pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray, 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[16] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Castle, Crisalli and Gaziano equally. In regard to the physicians rendering opinions in the miner's first claim for benefits, Drs. Gaziano, Abrahams, Crisalli and Zaldivar above Dr. Kress.

As discussed above, Dr. Castle determined that Mr. Kincaid had emphysema, not coal workers' pneumoconiosis. Dr. Castle found bullous emphysema. He explained that this type of emphysema is related to tobacco smoke, not coal dust exposure. He further explained that Mr. Kincaid did not have the rales, crackles or crepitations which are consistent with coal workers' pneumoconiosis. Dr. Castle also noted reversibility after use of bronchodilators on pulmonary function studies. He explained that coal workers' pneumoconiosis causes an irreversible defect. I find that Dr. Castle provided a reasoned and detailed medical opinion. I also find that Dr. Castle effectively supported his conclusion by discussing Mr. Kincaid's medical examinations.

Dr. Crisalli also determined that Mr. Kincaid had emphysema, not coal workers' pneumoconiosis. Dr. Crisalli found no evidence of an airway obstruction. He stated that he found decreased chest wall motion and decreased breath sounds bilaterally. Both of which are consistent with emphysema. Dr. Crisalli clarified that Mr. Kincaid's type of emphysema is due to cigarette smoking, not coal dust exposure. As did Dr. Castle, Dr. Crisalli noted that the pulmonary function studies showed improvement after bronchodilators, which is not consistent with coal workers' pneumoconiosis. I also find that Dr. Crisalli provided a reasoned and detailed medical opinion. He persuasively supported his finding of smoking-induced emphysema.

[16] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

In contrast with Drs. Castle and Crisalli, Dr. Gaziano concluded that Mr. Kincaid had coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Gaziano listed coal dust exposure and cigarette smoking as the cause of the conditions. In regards to Mr. Kincaid's second claim for benefits, Dr. Gaziano provided two examinations, on October 4, 2001 and August 26, 2004. At both examinations, Dr. Gaziano diagnosed coal workers' pneumoconiosis. Dr. Gaziano based his findings on chest X-rays taken at the examinations. At both examinations, Dr. Gaziano, who is not a Board-certified radiologist, interpreted the X-ray as having a profusion of 1/1 for coal workers' pneumoconiosis. The October 4, 2001 X-ray was later interpreted by three dually-qualified physicians as negative and by two dually-qualified physicians as positive. The August 26, 2004 X-ray was later interpreted by two dually-qualified physicians. One finding the X-ray positive and the other finding the X-ray negative. Due to the fact that Dr. Gaziano based his opinion on chest X-ray findings, which have been subject to conflicting interpretations, I find his opinion less persuasive than Drs. Castle and Crisalli. I find that Drs. Castle and Crisalli provided more medical evidence support for their conclusions.

In the miner's first claim for benefits, Drs. Gaziano, Abrahams, Kress, Crisalli and Zaldivar all diagnosed Mr. Kincaid with coal workers' pneumoconiosis. As noted above, all of the chest X-ray interpretations submitted in the miner's first claim for benefits were positive for coal workers' pneumoconiosis.

Dr. Crisalli submitted an opinion in the miner's first claim for benefits concluding that Mr. Kincaid had coal workers' pneumoconiosis. After further evidence has been developed, Dr. Crisalli has changed his opinion. He now finds that Mr. Kincaid did not have coal workers' pneumoconiosis. I find that Dr. Crisalli supported his current opinion with the objective evidence provided to him. As such, I find that Dr. Crisalli's opinion is that Mr. Kincaid did not have coal workers' pneumoconiosis.

Dr. Gaziano stated that he based his 1982 opinion that Mr. Kincaid had coal workers' pneumoconiosis on the objective evidence. Dr. Gaziano provided no further details of his conclusion nor did he explain how the objective evidence supported a finding of pneumoconiosis.

Dr. Abrahams reviewed the medical records and concluded that Mr. Kincaid had coal workers' pneumoconiosis and chronic bronchitis due to cigarette smoking. Aside from summarizing the miner's medical records, Dr. Abrahams provided no further explanation of his conclusion.

Dr. Kress also reviewed the miner's medical records. Based on the objective evidence, Dr. Kress determined that Mr. Kincaid had coal workers' pneumoconiosis. Dr. Kress also noted a mild obstructive impairment due to heavy cigarette smoking.

Dr. Zaldivar examined Mr. Kincaid in 1981 and found radiographic evidence of coal workers' pneumoconiosis and a mild obstructive impairment. He concluded that the obstructive impairment was caused by coal dust exposure and cigarette smoking. Aside from stating "radiographic" evidence of pneumoconiosis, Dr. Zaldivar made no further explanation of his conclusion that Mr. Kincaid had coal workers' pneumoconiosis.

Nor do I find the miner's COPD constitutes "legal" pneumoconiosis given that only Dr. Gaziano attributed it in part to coal mine dust exposure whereas Drs. Castle and Grisalli found it due solely to the lengthy smoking history.

In summary, I find the opinions of Drs. Castle and Crisalli entitled to the most weight. Although Dr. Gaziano is an experienced physician, I find Drs. Castle and Crisalli more persuasive. Given the progressive nature of pneumoconiosis, I find that the opinions submitted in the current claim are entitled to more weight than the opinions submitted in the miner's first claim for benefits. Furthermore, I find that the opinions submitted by Drs. Gaziano, Abrahams, Kress and Zaldivar did not provide detailed or descriptive statements of their findings.

The Claimant has the burden of proving the existence of coal workers' pneumoconiosis by a preponderance of the evidence. I accord the most weight to the evidence submitted in the miner's current claim for benefits. As discussed, most of the X-ray evidence, CT scan evidence and physicians' opinions submitted in the current claim are negative for coal workers' pneumoconiosis. I accord little weight to the evidence submitted in the first claim for benefits as it is over 15 years old and Claimant's condition appears to have changed in that time period. Thus, after analyzing and weighing all of the evidence, I find the Claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3rd Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[17] Section 718.204(b)(2)(i) through (b)(2)(iv) and (d) set forth criteria to

[17] The Board has held it is the claimant's burden to establish total disability due to CWP by a preponderance of the evidence. *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6

establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment and gainful employment requiring comparable abilities and skills; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc,* 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993).

Three pre-bronchodilator and two post-bronchodilator pulmonary function studies have been submitted in the miner's current claim for benefits. With the exception of Dr. Gaziano's August 26, 2004 pre-bronchodilator test, all of the tests produced qualifying results. Thus, I find that Mr. Kincaid proved, by newly submitted evidence, that he was totally disabled.

Four pre-bronchodilators pulmonary function studies were submitted in the miner's first claim for benefits. None of these studies produced qualifying results. As these studies are over fifteen years old, I accord little weight to their determination of total disability at the time of the miner's death.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

Three arterial blood gas studies were admitted at the October 18, 2005 hearing. One study produced qualifying results. The other two studies did not produce qualifying results. This is

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(1986)(*en banc*). 20 C.F.R. § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:
(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespirtory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

consistent with the earlier repeatedly non-qualifying results. As such, the Claimant did not prove total disability based on arterial blood gas studies.

Four arterial blood gas studies were considered in the miner's first claim for benefits. None of these studies produced qualifying results. I accord more weight to the most recent arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

As discussed above, Drs. Castle, Crisalli and Gaziano agree that Mr. Kincaid was totally disabled due to a pulmonary impairment. Thus, the Claimant has proven total disability by reasoned medical opinions.

In the miner's first claim for benefits, Drs. Abrahams, Kress, Crisalli and Zaldivar concluded that Mr. Kincaid was not totally disabled. Dr. Gaziano's 40% functional impairment finding constitutes a "total disability" finding. I accord little weight to these opinions in determining total disability as they are more than fifteen years old and the miner's condition clearly deteriorated in that time period.

After considering the pulmonary function studies, arterial blood gas studies and physician opinions, I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3rd Cir. 1993).

E. Cause of total disability

The revised regulations, 20 C.F.R. § 718.204(c)(1), requires a claimant to establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is

insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 7999946 (Dec. 20, 2000).

I find that Mr. Kincaid has not proven that he suffers from pneumoconiosis. Therefore, the issue of total disability causation is moot.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has established that a material change in conditions has taken place since the previous denial, because he was totally disabled at the time of death. The claimant did not have pneumoconiosis, as defined by the Act and Regulations. The claimant was totally disabled. His total disability was not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER

It is ordered that the claim of WALTER L. KINCAID for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.** At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter to **Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210**. *See* 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).